STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING 00 B. WING	07/07/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FRIENDSHIP HEALTHCARE	2630 S KEYSTONE AVE INDIANAPOLIS, IN46203

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F0000	This visit was for the Investigation of Complaint IN00092695. Complaint IN00092695 substantiated, Federal/State deficiencies related to the allegations are cited at F-279, F-314, and F-333. An unrelated deficiency is cited. Survey dates: July 05-07, 2011 Facility number: 004700 Provider number: 155741 AIM number: 100266630 Survey team: Debra Skinner RN Census bed type: SNF/NF: 44 Total: 44 Census payor type: Medicare: 03 Medicaid: 37 Other: 04 Total: 44 Sample: 03 These deficiencies also reflect state findings cited in accordance with 410 IAC	F0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	16.2. Quality review completed 7/12/11 Cathy Emswiller RN			
F0241 SS=D	The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality. Based on observation and interview, the facility failed to be attentive to an incontinent resident's needs in a timely manner regarding urine-soaked clothing in order to promote that resident's dignity. This deficient practice affected 1 resident reviewed for dignity in a sample of 4 (Resident #D). Findings include: During tour on 07/05/11 at 11:40 a.m., the DON (director of nursing) indicated Resident #D had advanced dementia, was able to ambulate independently, had mood swings at times, and had no recent changes or skin problems. During observation on 07/07/11 at 11 a.m., Resident #D was observed ambulating in the hallway near her room with obviously wet areas to the back of her shirt mid-back, and to the back of the pants down both legs to the knees.	F0241	1) C.N.A. #1 was terminated on July 7, 2011 for poor job performance. His failure to address Resident # D's needs was one example, but was not the only reason for termination of his employment.2) All residents in the facility are identified as having potential to be affected.3) Three C.N.A.s per week from various shifts will be reviewed by the charge nurse to ensure that the residents in their care were provided with care in accordance to the C.N.A. Assignment Sheet. After the review, the C.N.A. Assignment sheet will be signed by the charge nurse and given to the Director of Nursing for review in morning meeting. This will continue until all C.N.A.s employed at Friendship Healthcare have been reviewed. 4) After all C.N.A.s have been reviewed, three C.N.A.s from various shifts will be reviewed each month in the same manner on an ongoing basis. These C.N.A. reviews will be discussed	07/29/2011

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	Housekeeper #1 was observed to stop CNA #1 and relate that Resident #D needed changed. Resident #D had then gone into her room and sat down on a chair beside her bed. CNA #1 was observed to walk past Resident #D's room and enter the room across the hall. CNA #1 was then observed to come out of another resident's room with a bag of soiled linens which were placed in a dirty linen receptacle and taken to the dirty linen shute on another hall. Resident #D was observed at 11:05 a.m., calmly sitting on her bed with her wet clothes still on. At 11:25 a.m., Resident #D was observed sitting on her bedside chair trying to remove her pants which were down below her knees at the time. At 12:30 p.m., Resident #D was observed ambulating in the hall with dry clothing on. During interview on 07/07/11 at 3:45 p.m., the DON indicated CNA #1 had been terminated due to having disregarded Housekeeper #1's observation regarding Resident #D's having needed changed. The DON indicated this CNA had been counseled one time previously for a similar incident and so was terminated for a second event. 3.1-3(t)		in morning meeting after they are completed.5) Date of Completion 7/08/2011. ADDENDUM: 3. The competency and effectiveness of each C.N.A. is observed and evaluated by Charge Nurses and the Director of Nursing. A teaching session will be conducted for the C.N.A.s and the Charge Nurses on 7/29/2011, to reiterate zero tolerance for poor incontinence care or any other poor practice. The Charge Nurse will be responsible for randomly observing two residents on each C.N.A.s assignment, utilizing an audit form three days per week times four weeks. The assignment audits for the provision of timely incontinence care will be reviewed daily by the Director of Nursing at the facility's morning meeting times four weeks. The C.N.A. assignment sheets will be signed by both the Charge Nurse and the C.N.A., with observation results, and given to the Director of Nursing each morning. The audits will be reviewed by the DON at the facility's morning meeting for four weeks, twice weekly for two months, then once weekly for an additional three months. Any C.N.A. or Charge Nurse found not performing their job will be counseled and disciplinary action will be given for failure of required performance standards. 4. The Don or designee will audit	

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			two C.N.A.s for proficiency each month as a method to monitor compliance times six months. The audit tools and assignment sheets will be reviewed by the Quality Assurance Committee for compliance of timely incontinence care monthly for three months and then quarterly thereafter. When 100% compliance is achieved, the audits will continue at a rate of one per month and will be discussed quarterly at the QA meeting to monitor continued compliance. Date of Completion 7/29/2011	
F0279 SS=D	A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). Based on record review and interview, the facility failed to update a resident's care plan regarding changes in pressure ulcer condition and treatment regarding nursing measures and dietary	F0279	1) Resident #B's care plan was reviewed and updated to include all interventions that are in place to address his skin issues.2) All residents with pressure areas are identified as having potential to be	07/29/2011

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	recommendations in 1 of 3 residents reviewed for care plans in a sample of 4 (Resident #B). Findings include: Review on 07/05/11 at 1:35 p.m., of Resident #B's clinical record indicated: Resident #B had the diagnoses which included, but were not limited to, diabetes type II, chronic renal insufficiency, hypertension, fragile skin, peripheral vascular disease, urinary retention with supra-pubic catheter, MRDD (mental retardation developmentally disability), dementia, paranoid schizophrenia and paraplegia due to stroke. A quarterly MDS (minimum data set) assessment dated 05/02/11, indicated the resident had the diagnoses of dementia, schizophrenia, and MRDD, but had no current problems with depression; was totally dependent for all ADL's (activities of daily living); had impairment regarding range of motion to both upper and lower extremities due to paraplegia; had a catheter and was incontinent of bowel; reported mild, constant pain; had no problems with falls or weight loss; had 3 stage II pressure ulcers and one unstageable pressure ulcer; received a daily antipsychotic medication and no		affected. 3) All residents with pressure ulcers have had their care plans reviewed by the interdisciplinary team and the care plans have been updated to include all interventions that are in place to address wound healing. Care plan books will be brought to morning meeting Monday through Friday. All physicians orders are reviewed in morning meeting. Care plans will be updated at that time. Orders written on weekends and holidays will be reviewed the next business day.4) A list of residents whose care plans were updated will be kept with the morning meeting minutes for monitoring purposes. These will be reviewed by the Administrator daily. This system will be ongoing.5) Date of Completion 7/22/2011. ADDENDUM: 3) The C.N.A. assignment sheets have been updated with care interventions for each resident. Residents that require wound dressing changes are noted on the assignment sheets as a reminder to the C.N.A. to write the date of the dressing observed daily during provision of care. These assignment sheets are then signed by the C.N.A. then reviewed and signed by the Charge Nurse, as duties are reviewed and completed times six months. The C.N.A. assignment sheets will be given to the Director of Nursing each morning to review in the facility's morning	

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	insulin injections. Physician's orders for June 2011 included, but were not limited to: Mechanical soft with thin liquids (no date of initiation) Arginaid 1 packet twice daily (05/16/11) Ensure 120 cc (cubic centimeters) three times daily (03/07/11) Remeron 7.5 mg (milligrams) po (by mouth) daily at bedtime (05/18/11) Vitamin C 500 mg po twice daily (07/14/10) Silver sulfadiazine cream apply topically to buttocks and cover with ABD pad (large thick absorbent pad), change daily 6 a-2 p shift (04/29/11) The resident's weight record indicated: 01/16/11: 122.6 lbs (pounds) 02/13/11: 121.2 lbs 03/13/11: 109.8 lbs 04/2011 (no day indicated): 121.3 lbs 05/22/11: 106.1 lbs 06/15/11: 117.6 lbs *This document had no documentation to		meeting for four weeks, then twice weekly for two months, then once weekly for an additional three months. An C.N.A. found not performing their job will be counseled and disciplinary action will be given for failure of required performance standards. 4) The Director of Nursing or designee will review the audits and updated assignments with the Quality Assurance Committee monthly times three months and then quarterly thereafter. When 100% compliance is achieved, the audits will continue ongoing at a rate of one per month and will be discussed at the QA meeting quarterly for monitoring of continued compliance. Date of Completion 7/29/2011	

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	indicate re-weights had been done. A care plan problem dated 10/20/10, indicated "Resident needs therapeutic diet due to hypertension, DM (diabetes mellitus), and no teeth. He has a recent history of significant weight loss". Interventions included, but were not limited to, "diet as ordered (pureed diet with thickened liquids)". There was no documentation to indicate the dietary recommendations for supplements had been recognized or regarding changes in the resident's weight, medications, and diet. A care plan problem dated 08/16/10, for "Open areas L (left) buttock & (and) coccyx & chronic red dermatitis bilateral buttocks/thighs". This care plan problem did not indicate the nature of the resident's open areas, nor did the interventions include any treatments, medications or dietary supplements. Another care plan problem for "skin breakdown" dated 10/20/10, indicated "risk for skin breakdown due to total dependence on staff for bed mobility, total incontinence of bowel, peripheral vascular disease, and long term history of pressure ulcers. Currently has pressure ulcers". This care plan problem failed to indicate how many pressure ulcers were present,			

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	the stage/site, nor did it indicate what medications, treatments or dietary supplements were being used to treat these areas. This care plan problem also failed to indicate the resident's pressure ulcers would be assessed/monitored on a regular basis. During interview on 07/07/11 at 9:15 a.m., the DON (director of nursing) indicated there were no other care plans available regarding Resident #B other than those in the care plan book. This Federal tag relates to Complaint IN00092695. 3.1-35(a) 3.1-35(b)(1)			
F0314 SS=G	Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. Based on interview, observation, and record review, the facility failed to change	F0314	1) Friendship Healthcare identified and self-reported LPN	07/29/2011

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	a resident's dressing and assess for further breakdown of a stage II pressure ulcer for 4 days until such time as the stage II pressure ulcer had become a stage IV area. This deficient practice affected 1 of 3 residents reviewed for pressure ulcers in a sample of 4 (Resident #B). Findings include: Review on 07/05/11 at 1:35 p.m., of Resident #B's clinical record indicated: Resident #B had the diagnoses which included, but were not limited to diabetes type II, chronic renal insufficiency, hypertension, fragile skin, peripheral vascular disease, urinary retention with supra-pubic catheter, MRDD (mental retardation developmentally delayed), dementia, paranoid schizophrenia and paraplegia due to stroke. A quarterly MDS (minimum data set) assessment dated 05/02/11, indicated the resident had the diagnoses of dementia, schizophrenia, and MRDD, but had no current problems with depression; was totally dependent for all ADL's (activities of daily living); had impairment regarding range of motion to both upper ad lower extremities due to paraplegia; had a catheter and was incontinent of bowel; reported mild, constant pain; had		#1 failing to perform treatments as ordered, and falsely documenting that the treatments were done. We addressed this issue and reported it to ISDH on 7/01/2011, the same day that we terminated that nurse‘s employment.In addition to reporting to the Indiana State Department of Health, this was also reported to the Indiana State Board of Nursing and the Indiana Attorney General’s office. Also, the evening shift charge nurse was terminated due to not addressing this issue after a C.N.A. reported it to her.2) All residents on the unit that LPN #1 worked are identified as having potential to be affected.. A ‘skin sweep’ of all residents in the building was performed. No residents other than Resident #B, originally cited, were found to have any decline in skin condition.3) Wound rounds will be conducted once weekly on Fridays as a method to monitor wound care. Additionally, all staff were inserviced concerning resident neglect on 7/15/2011. C.N.A.s will be instructed to observe dressings when they provide ADL care to their residents, and to report any dressings dated more than 24 hours ago to the charge nurse. This C.N.A. instruction will take place by 7/25/2011. Any C.N.A.s not scheduled between now and 7/25 will be inserviced prior to the start of their next scheduled	

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	no problems with falls or weight loss; had 3 stage II pressure ulcers and one unstageable pressure ulcer; received a daily antipsychotic medication and no insulin injections. The June 2011 Physician's orders included, but were not limited to: Arginaid packet-cherry 1 packet twice daily (05/16/11) Divalproex 1250 mg (milligrams) po (by mouth) daily (07/14/10) Ensure 120 cc (cubic centimeters) po tid (three times daily) (03/07/11) Vicodin 5/325 mg 2 tablets po 1 hour prior to dressing change (04/22/11) Vicodin 5/325 mg 1 tablet po daily at 9 p.m. (04/22/11) Remeron 7.5 mg po at bedtime (05/18/11) Multivitamin 1 po daily for supplement (05/18/11) Vitamin C 500 mg po daily for supplement (07/14/11) Silver sulfadiazine cream apply topically to buttocks and cover with ABD pad		shift.4) A Treatment Audit Tool will be used to ensure that treatments are being done as ordered. The treatment audit tool will be reviewed daily by the DON and Administrator during morning meeting for two weeks, then twice weekly for two months. Pressure ulcers and skin care will be on the agenda of the Quality Assurance Committee each month on an ongoing basis as a method to monitor effectiveness of our skin care program. 5) Date of Completion 7/25/2011 ADDENDUM: 3) A designated wound nurse will conduct wound rounds once weekly on each unit as a method to monitor wound care. The Director of Nursing will review the findings daily at the facility morning meeting times four weeks. The results of the wound rounds will then be reviewed by the Administrator and Director of Nursing weekly for two months. The DON currently monitors, and will continue to monitor the wound round documents with the designated wound nurse weekly. 4) Pressure ulcers and all other skin care issues will be on the agenda of the Quality Assurance Committee each month as a method to monitor the effectiveness of our skin care program times six months, then quarterly thereafter. Date of Completion 7/29/2011	

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	(large thick absorbent pad), change daily 6 a-2 p shift (04/29/11) Resident to be up in chair at degrees as much as possible (no initiation date) Keep heels floating off bed (no initiation date) A TAR record (treatment administration record) for June 2011 indicated staff had changed the dressings to the resident's "buttocks" (silvadiazine and ABD pad) daily as ordered on 06/23 through 06/29/11. A fax communication dated 07/05/11, indicated the resident's physician had given the order "santyl to heel and coccyx slough areas change daily. On back only for meals. Wound gel to wound beds on buttocks and heel . Calmoseptine to excoriated areas on buttocks..." Review of the weekly "Pressure Ulcer Reports" indicated: "Coccyx: date identified: 04/14/11--stage II: 1.9 cm long x (by) 1.1 cm wide x 0.1 cm deep no drainage 06/02/11- -stage II: 1.6 cm long x 1.0 cm wide x 0.1 cm deep 06/09/11-			

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	-stage II: 5.0 cm long x 4.0 cm wide x (blank) with 80% slough During interview on 07/06/11 at 1 p.m., the Director of Nursing was unable to provide weekly pressure ulcer assessment reports regarding this resident's coccyx pressure ulcer past 06/09/11 and up to 07/01/11, as these reports as "they had not been done" . Dietary progress notes dated 04/18/11 (which was the most recent entry), indicated no documentation regarding the resident's pressure ulcers. A care plan problem dated 08/16/10, for "Open areas to left buttock & (and) coccyx, chronic red dermatitis bilateral buttocks/thighs". This care plan for skin breakdown had not been updated to reflect the resident's different pressure ulcers and their changes in progress/regression, nor did the care plan reflect treatments or dietary recommendations of any kind. A hepatic profile lab report dated 05/02/11, indicated a total protein of 5.8 (low) and an albumin of 2.8 (low). During interview on 07/06/11 at 9:15 a.m., the Director of Nursing indicated Resident #B's coccyx area had been a			

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	stage II, but had been found to be a stage IV on 07/01/11, when RN #1 had gone to change the resident's dressings with RN #1 having found the dressing to have a date of 06/26/11. The Director of Nursing indicated skin had come off with the resident's dressings when the dressings had been removed in several places causing several open areas. The Director of Nursing further added the resident had a long history of fragile skin with dermatitis to the buttock area as well as had a history of pressure ulcers with multiple skin flap procedures before admission to the facility. During interview on 07/06/11 at 1 p.m., the Director of Nursing indicated LPN #1 had been responsible not only for daily dressing changes/assessments, but had also been responsible for weekly measurements of the resident's wounds, but had not done the resident's coccyx measurement/assessment since 06/09/11, as none were found. During observation on 07/07/11 at 10:10 a.m., LPN #2 removed the resident's dressing to the coccyx area. The coccyx wound was approximately the size of a quarter with 100 % yellow slough. The wound margins were smooth and there was no drainage coming from the wound. There were 5 irregularly shaped shallow			

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	areas around the lower perimeter of the coccyx wound which were bright red in color with little bleeding. LPN #1 indicated these 5 irregular areas had not been present until 07/01/11, when the 4 day old dressing had been removed (ABD and Coverroll). During observation on 07/07/11 at 12:45 p.m., the NP (Nurse Practitioner) examined the resident's coccyx wound and indicated the wound measured 2 cm x 2 cm and had a depth of less than 0.1 cm with no tunneling. The NP gave orders for a wound culture to be done and to give Septra DS (an antibiotic) until the culture was back. During interview on 07/07/11 at 1 p.m., the NP indicated the resident had chronic dermatitis to his bottom which made the skin to that area very friable and prone to breakdown. The NP further indicated the resident had a long history of skin problems and had required multiple skin flap procedures due to non-healing pressure ulcers in the past. This Federal tag relates to Complaint IN00092695. 3.1-40(a)(2)			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155741	A. BUILDING 00 B. WING	07/07/2011

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F0333 SS=D	The facility must ensure that residents are free of any significant medication errors. Based on interview and record review, the facility failed to administer insulin according to physician's orders as a resident had received insulin for the ordered amount by two different nurses within a short time period. This deficient practice affected 1 of 3 residents reviewed for insulin injections in a sample of 4 (Resident #A). Findings include: Review on 07/05/11 at 12:15 p.m., of Resident #A's clinical record indicated: Resident #A had the diagnoses which included, but were not limited to, hepatitis C with hepatic encephalopathy, diabetes mellitus type I, CHF (congestive heart failure), morbid obesity, schizophrenia, and portal hypertension. A quarterly MDS (minimum data set) assessment dated 05/26/11, indicated the resident had the diagnoses of hepatitis C, depression and schizophrenia and made poor decisions; was independent with bed mobility, transfers and ambulation and required supervision with eating and hygiene; was continent of bowel/bladder; had no problems with weight loss or gain;	F0333	1) Friendship Healthcare identified and self-reported medication error involving Resident # A's insulin. We addressed this issue and reported it to ISDH on 6/23/2011. LPN #3 had requested that LPN #4 administer insulins on the South unit (Resident #A's unit). LPN #3 then gave the insulin to Resident #A herself and failed to inform LPN #4 that she had done so. Subsequently, LPN #4 also administered insulin to Resident #A. LPN #3 is no longer employed at our facility. 2) All residents on insulin have been identified as having potential to be affected. It has been determined that no other residents had a similar medication error.3) All nurses were instructed to take responsibility for medication administration on their respective units. The only time a nurse will be responsible for administering insulins on another unit is if a QMA is scheduled on that unit. They have also been reminded of the importance of good communication between staff members. 4) Insulin administration will be recorded on an audit tool that will be reviewed daily by the Director of Nursing for four weeks, then twice per week for two months. 5) Date of Completion 7/08/2011. ADDENDUM:	07/29/2011

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	received both daily antidepressant and antipsychotic medications as well as a daily diuretic; and had no problems with falls or pressure ulcers. Physician's orders for June 2011 indicated, but were not limited to: Metformin 500 mg (milligrams) po (by mouth) twice daily (04/13/10) Lactulose 30 cc (cubic centimeters) four times daily for increased ammonia levels (06/03/10) Lantus insulin inject 96 units Sub Q (subcutaneously) at bedtime (05/10/11) Novolog insulin inject 18 units Sub Q with snacks (08/17/10) A nurse's note dated 06/22/11 at 10 p.m., indicated LPN #3 had administered Resident #A's routine insulin at 9:15 p.m., and had then charted it on the MAR (medication administration record) and had then observed LPN #4 coming from Resident #A's room with an empty insulin syringe. LPN #4 had given Resident #A his routine insulin without having realized LPN #3 had already given the routine insulin to Resident #A. The resident's Physician had been notified of the medication error with the resident having		3. All nurses will be inserviced on their responsibility for medication administration on their own respective units. Insulin audits will be filled out daily by the Charge Nurse and reviewed by the Director of Nursing at each facility morning meeting daily times four weeks. Then we will continue twice per week on each unit for two months until we achieve 100% compliance. There will be two random audits reviewed by the Director of Nursing or designee monthly for an additional three months, then we will continue to audit one resident per unit each month times three months. Any licensed nurse found not to be performing their job will be disciplined for failure to follow required standards of practice. 4. The insulin audits and disciplinary action related to medication administration (if any) will be reviewed by the Quality Assurance Committee monthly for three months. When 100% compliance is achieved, the insulin audits will continue at the rate of one audit per unit per month, and will be reviewed at the quarterly QA meeting. Date of Completion 7/29/2011	

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	been sent to the ER (emergency room) for evaluation and treatment. The resident had returned to the facility on 06/23/11, with no new orders. The resident's blood sugar had been checked on 06/22/11 at 9 p.m., and was 172 and at 9:35 p.m. had been 110. A hospital discharge summary dated 06/23/11, indicated the resident had never become hypoglycemic at anytime and was kept for observation without complication. This document indicated the resident had no negative outcome from having received the overdose of insulin on 06/22/11 at the facility. During interview on 07/05/11 at 3:55 p.m., LPN # 4 indicated on 06/22/11, at the time she had drawn up Resident #A's routine evening insulin, LPN #3 had not yet documented on the MAR that she had already given Resident #A's insulin, nor had LPN # 3 communicated that she had given Resident #A's routine evening insulin until after the fact. During interview on 07/05/11 at 12:40 p.m., the Director of Nursing provided documentation to support that all nurses were inserviced on 06/30/11, regarding appropriate communication between staff, the medication pass, and giving insulin.			

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	This Federal tag relates to Complaint IN00092695. 3.1-25(b)(9)			